# *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*

# DISABILITY -- NEW FREEDOM INITIATIVE

*Sections 1860D-31 and 1860D-2*

Background

Individuals with disabilities who are Medicare beneficiaries and who are not eligible for Medicaid do not currently have a prescription drug benefit. The President's New Freedom Initiative (NFI) has made a variety of proposals to Congress to improve the lives of people with disabilities.

New Provisions in the Act

Starting in 2004, disabled individuals who are eligible for Medicare (but not for Medicaid) will be able to enroll in a Medicare endorsed prescription drug discount card. Cards will provide discounts of between 10 and 25 percent off the price of drugs. Low-income Medicare beneficiaries who have incomes below 135% FPL and who do not have other prescription drug coverage (except for State-Only Pharmacy benefits or M+C drug benefits) will be eligible for transitional assistance of $600 in each of 2004 and 2005 to assist them with the costs of their drugs. There is no asset test that must be satisfied in order to receive this assistance. Minimal coinsurance applies to Transitional Assistance recipients (5% for those under 100% FPL and 10% for those under 135% FPL).

Starting in 2006, the new Medicare drug benefit will provide a benefit to disabled individuals who are Medicare beneficiaries, reducing their health care costs. Low-income disabled individuals eligible for Medicare may also qualify for subsidies for Part D premiums and cost-sharing.

The elderly with disabilities who are dual eligible individuals (i.e., they qualify for Medicaid and Medicare and can qualify for Medicaid due to a disability through the SSI Medicaid eligibility pathway) will receive their drug coverage through Medicare. State Medicaid programs will no longer provide coverage for prescription drugs for dual eligible individuals except for certain drugs (as defined in statute) that Medicare will not cover. Dual eligible individuals will automatically qualify for low-income subsidies of Part D premiums and cost-sharing.

Disabled individuals who are not Medicare or Medicaid beneficiaries will not be able to obtain the Medicare Part D benefit but may continue to receive drug coverage through existing Medicaid buy-in programs that may be offered by the State, State Pharmacy Assistance Programs (that may now have more funds available to assist this population), and/or Medicaid waivers.

The Part D low-income subsidy program provides premium and cost-sharing subsidies for three groups of Medicare beneficiaries. These low-income subsidy groups are:

- Group 1: full dual-eligibles with incomes below 100% FPL (no asset test).
- Group 2: full dual eligibles with incomes at or above 100% FPL, as well as non-dual eligible Medicare beneficiaries with incomes less than 135% FPL who meet three times the SSI asset test of $6,000 for an individual and $9,000 for a couple in 2006 (increased by the CPI-U in subsequent years).Group 3: Medicare beneficiaries with incomes less than 150% FPL who meet the resource standard of $10,000 for an individual or $20,000 for a couple in 2006 (increased by the CPI-U in subsequent years).

The low-income subsidies are structured as follows:

- Beneficiaries in Group 1 receive the following:
  - a full premium subsidy up to the benchmark premium amount;
  - a full subsidy for the deductible;
  - prescriptions with only a $1 copayment for each generic drug or multiple source preferred drug and a $3 copayment for any other drug, up to the out-of pocket limit of $3,600;
  - prescriptions with $0 copayments after the out-of-pocket limit is reached; and
  - limits on late enrollment penalties -- twenty percent of any applicable late enrollment penalties would apply for the first five years, after which no penalty would be imposed.

- Beneficiaries in Group 2 receive the following:
  - a full premium subsidy up to the benchmark premium amount;
  - a full subsidy for the deductible;
  - prescriptions with only a $2 copayment for each generic drug or multiple source preferred drug and a $5 copayment for any other drug, up to the out-of pocket limit of $3,600;
  - prescriptions with $0 copayments after the out-of-pocket limit is reached; and
  - limits on late enrollment penalties -- twenty percent of any applicable late enrollment penalties would apply for the first five years, after which no penalty would be imposed.

- Institutionalized persons who are full-benefit dual eligibles are exempt from cost sharing, regardless of whether they are in Group 1 or Group 2. They would not be required to use their personal needs allowance to pay cost sharing.

- Beneficiaries in Group 3 receive the following:
  - a reduction of their monthly premium determined on a sliding scale based on income;
  - a reduction of the deductible to $50;

- prescriptions with a 15% percent copayment, up to the out-of pocket limit of $3,600; and
- after the out-of-pocket limit is reached, prescriptions with only a $2 copayment for each generic drug or multiple source preferred drug and a $5 copayment for any other drug.

- Cost-sharing (other than for full benefit dual eligibles with incomes below 100% FPL), deductibles and coinsurance for these groups are indexed beginning in 2007 by the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the U.S. for eligible beneficiaries as determined by the Secretary of HHS for a 12 month period ending in July of the previous year, using a methodology determined by the Secretary. Cost-sharing for full benefit dual eligibles with incomes below 100% FPL) would be indexed to the CPI-U.

- The premium subsidy amount for a full subsidy eligible beneficiary (Group 1 or Group 2) is the low-income benchmark premium for a PDP region. The low-income benchmark premium is equal to the weighted average of premiums of all prescription drug plans offered by the same PDP or a weighted average of premiums of all prescription drug plans offered by multiple PDP sponsors in a region. A low-income subsidy may not be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in a region.

- Eligibility for subsidy eligible individuals is to be determined by State Medicaid agencies or by the Social Security Administration. Determinations will be effective beginning with the month that a subsidy eligible beneficiary applied and the determination will remain effective for up to one year. Re-determinations and appeals for eligibility determinations by the state will follow existing re-determination and appeals set under each state's Medicaid Plan. The re-determinations and appeals for eligibility determinations by SSA will be determined by the Commissioner of SSA. The Commissioner will establish procedures for appeals similar to those in section 1631(c)(1)(A), which is the hearings and review process for disability.

- Full-benefit dual eligibles and recipients of supplemental security income (SSI) benefits are deemed to be eligible for the low-income subsidies applicable to beneficiaries with incomes less than 135% FPL (Group 2), except that full benefit dual eligibles with incomes below 100% FPL will be eligible for the low-income subsidies for Group 1. The Secretary may also deem QMB's, SLMB's, and QI-1's as low-income subsidy eligible individuals in these Groups.

- Income determinations will be conducted following SSI guidelines without regard to the application of 1902(r)(2) income disregards. With respect to resources, the Secretary may permit states to use the same asset or resource methodologies that are used with respect to determining eligibility for a QMB individual (section 1905 (p)) so long as the methodology does not result in any significant differences in the number of individuals determined to be subsidy eligible under Part D.

- The Secretary and the Commissioner of Social Security shall develop and disseminate to states a model, simplified application form and process for determination and verification of an eligible beneficiary's assets or resources. The application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources and their valuation. The form will contain copies of recent statements from financial institutions in support of the application. Matters attested to in the application shall be subject to verification.

- Residents of the Territories are not eligible for the low-income subsidies available to residents of states under Part D, but may be eligible for assistance under the special Territorial provisions of Part D in Section 103 (new section 1935(e)).

- The Secretary of HHS shall develop a process to provide notification of a PDP sponsor or a Medicare Advantage organization offering a drug plan that an enrolled beneficiary is eligible for a subsidy and the amount the amount of the subsidy. The sponsor or plan, in turn, reduces the premiums or cost sharing that would otherwise apply and submits to the Secretary information on the reduced amount. The Secretary periodically and on a timely basis must reimburse the PDP sponsor or MA organization for the amount of the reduced premiums and cost sharing. Reimbursement may be computed on a capitated basis. The Secretary must ensure the confidentiality of any individually identifiable information.